

CONSENT TO MEDICAL TREATMENT

I, or authorized representative acting on behalf of the patient, or as a parent or legal guardian of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of treatments or examination at Youens & Duchicela Clinic.

Patient Name: _____ Birth date: _____

Signed: _____ Date: _____

Relationship, if other than patient: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Youens and Duchicela Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority